is to be found in the blood. The chemical nature of this poison is similar to carbamic acid, and a detailed report is given of a series of experimental researches. JELLIFFE.

CLINICAL NEUROLOGY.

233. EIN WEITERER FALL VON SOLITÄRER TUBERCULOSE DES RÜCKENMARKS, ZUGLEICH EIN BEITRAG ZUR LEHRE VON DER BROWN-SÉQUARD'SCHEN HALBSEITENLÄHMUNG. (Another Case of Solitary Tuberculosis of the Spinal Cord, at the Same Time a Contribution to the Brown-Séquard Paralysis). L. R. Müller (Deutsche Zeitschrift für Nervenheilkunde, vol. 12. 1898, p. 288).

A man, 46 years old, who had phthisis, became very weak in the right lower limb, while the power in the left was retained. He had retention of urine, exaggerated knee-jerk, especially on the right side, and disturbed sensation on the left side. The upper extremities were not affected. The senses of pain and temperature were completely lost on the left side below the ribs. The senses of touch, pressure and location were not disturbed anywhere. Sensation was somewhat impaired in a small area over the right nipple. A solitary tubercle was found in the right side of the second thoracic segment of the spinal cord. The left half of the cord was compressed by the growth, but otherwise very little altered. Although the clinical signs of spinal disease had lasted five weeks, secondary degeneration was not very important. A slight degeneration was noted in the left anterolateral column, beginning a little above the tubercle. This, the writer believes, was due to destruction of the gray matter, especially of the posterior horn, on the right side. It is only in rare cases that the existence of this tract in the anterolateral column, arising in the contralateral gray matter, has been indicated by pathological findings. The vertebræ and membranes were normal. A slight degeneration of the posterior columns in the lower thoracic and lumbar regions was supposed to be similar to that seen in pernicious anæmia and marasmus. The diagnosis of a solitary intramedullary tumor in the right half of the cord was made before death, and was founded on clinical phenomena, in a phthisical patient, indicating a partial transverse lesion. The free movement of the vertebral column, the absence of painful areas along the spine, the painless development of the hemiplegia, were regarded as indicative of the integrity of the spinal vertebræ and membranes. Müller agrees with Bruns that in spinal paraplegia the lesion is usually located too low in the cord.

Although only one-half of the cord was destroyed, the paralysis was not truly of the Brown-Séquard type. The weakness of the right lower limb did not amount to paralysis, and the disturbance of sensation on the left side was syringomyelic in type. The existence of naked axis cylinders, which escaped detection within the tubercle, may possibly explain the partial paralysis, but not the disturbed sensation. The views concerning Brown-Séquard paralysis are correct as regards pain and temperature senses, but not as to tactile sense; the former senses, the author thinks, are altered by lesion of the posterior horn of the side on which the fibres enter the cord, and by lesions of the anterolateral column of the opposite side.

SPILLER.

234. SUR UN CAS DE MYÉLITE SUBAIGUE DORSO-LOMBAIRE [Sub-Acute Dorso-lumbar Myelitis (due probably to infection by way of the uterus)]. Mongorer et Carière (La Presse Médicale, Vol. 55. 1897, p. 8).

The authors describe a case of myelitis affecting the portion of the cord below the seventh dorsal segment, and give a very complete account of the changes found both in the cells and fibre tracts and in the vessels of the cord on examination by recent staining methods. They suggest that the disease may have been the result of an infection from the uterus, as the patient had had for some time an unhealthy condition of the endometrium, and had been subjected to the operation of curettage about a month before the onset of the myelitis.

ALLEN.

235. PATHOGÉNIE DE LA RIGIDITÉ MUSCULAIRE ET DA LA CONTRACTURE DANS LES AFFECTIONS ORGANIQUES DU SYSTÈME NERVEUX (Pathogenesis of Muscular Rigidity and Contractures in Organic Disorders of the Nervous System). A. Van Gehuchten (La France Méd., 44, 1897, p. 629).

The physiological mechanism of muscular rigidity and contraction, which are constant symptoms in organic hemiplegia and spasmodic paraplegia, are discussed by the author. The theories advocated by Follin, Hitzig, Straus, Marie, Freud, Jackson and others, according to which these phenomena are of muscular, spinal or cerebellar origin, prove to be inadequate in explaining the clinical and anatomical facts. Besides, it would be difficult to find a solution applicable to both hemiplegic and spasmodic contractures, the underlying cause not necessarily being the same. The author maintains that spasmodic contraction is an active process, that is, an exaggeration of normal muscular tonus, of *cerebral* origin, due to interruption in the course of the cortico-spinal fibres, with preservation of corto-ponto-cerebello-spinal nerves, which latter keep the cells of the spinal cord under the control of the motor cells of the cortex. On the other hand, hemiplegic contracture has quite a different genesis, the influence of the cerebral cortex upon the motor spinal cells and the corresponding paralysed muscles being cut off by the lesions, and if contractures develop in this case, they are of peripheral origin, due to a difference in degree of paralysis between the flexor and extensor muscles. The former are usually less involved than the latter, therefore the frequency of post-hemiplegic flexion contractures. If, on the other hand, the paralysis is of equal intensity in all the muscles of the extremity, no contractions will result, and there will be a flaccid condition.

MACALESTER.

236. DES PARALYSIES POST-ANESTHÉSIQUES (Post-Anæsthetic Paralysis). Ed. Schwartz (Gazette des Hopitaux, 70, 1897, p. 1,248).

Following operations performed under general anæsthesia there are sometimes observed paralyses which have no pathological connection with the seat of operation, and surprise both patient and surgeon by their unexpected appearance. The following belongs to this class of cases:

A man, æt. 45, was operated on for a small inguinal hernia. During the operation, which was performed under chloroform anæsthesia, there was a slight attack of cardiac and respiratory syncope, which was easily and promptly overcome by artificial respiration. On emerging from the chloroform narcosis the patient observed a feeling of formication in the right hand, especially in the thumb and index finger, and he could not readily move the two affected fingers. The next day there was a complete paralysis of the flexor longus pollicis and the flexors of the index finger. All the other muscles of the upper extremity were intact. There was no anæsthesia or hyperæsthesia. When he tried to move his lower limbs there was observed a well-defined paralysis of the right quadriceps extensor femoris. The paralysis was thus limited to the right side, involving